LOS ANGELES COUNTY

AREA AGENCY ON AGING

SUPPORTIVE SERVICES PROGRAM

TITLE IIIB

CONTRACTOR TRAINING AND ASSISTANCE GUIDE

SUPPORTIVE SERVICES PROGRAM (SSP)

TITLE IIIB

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Los Angeles County
Community and Senior Services

Our Mission:

"We save lives"

Our Philosophy:

Our aim is to expand on the County's Strategic Plan of ensuring: Service Excellence, Workforce Excellence, Organizational Effectiveness, Fiscal Responsibility, and Children and Families' Well-being.

We are committed to provide our County's residents with services that uphold our Department's mission.

We strive to develop high quality services that promote self-sufficiency, prosperity, and the well-being of individuals, families, and business alike.

Supportive Services Program (SSP)

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Purpose:

The purpose of the Supportive Services Program is to aid older individuals to live as independently as possible and avoid early institutionalization.

The Supportive Services Program provides Case Management, Alzheimer's Day Care, Outreach, Registry and in-home services such as Personal Care, Homemaking, and Respite to older individuals (60+). Preference is given to those older individuals with the greatest economic and/or social needs.

Services are limited to individuals residing in Los Angeles County, excluding the City of Los Angeles.

Supportive Services Program (SSP)

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Learning Objectives:

At the completion of this course of training, you should be able to:

- ***Demonstrate a complete knowledge of the Supportive Services Program and its services;***
- ***Effectively use the Universal Intake Form and accurately input data into Social Assistance Management System (SAMS);***
- ***Comply with your fiscal responsibility;***
- ***Comply with your contractual obligations; and***
- ***Enhance your knowledge of issues related to providing services through the Supportive Services Program.***

CLIENT ELIGIBILITY

Supportive Services Program (SSP)

Title IIIB

CLIENT ELIGIBILTY

A person is eligible to receive Supportive Services Program services if he/she is an older individual. An older individual is defined under Title III-B, Supportive Services Program as a person that is 60 years of age or older.

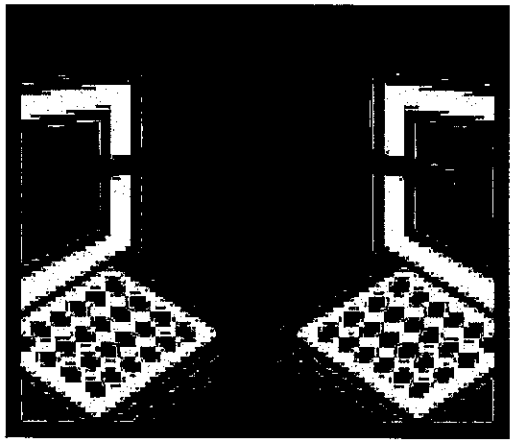
- There is an emphasis on those older individuals who are in the greatest economic and social need, with particular attention to low income minority older individuals.

- Older individuals who are frail*, homebound by reason of illness or disability, or otherwise isolated, shall be given priority for services.

  *Frail is defined as an older individual who is unable to perform at least two Activities of Daily Living; or due to a cognitive or other mental impairment, requires substantial supervision.

- The emphasis on older individuals and priority of services are not to be confused with the eligibility requirement. The only eligibility requirement is to be 60 or older.

REGISTERED SERVICES



Supportive Services Program (SSP)

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REGISTERED SERVICES

Registered Services for SSP include:

- Case Management
- Homemaker
- Personal care

Registered Services requires "Detailed Client Profile" information consisting of specific demographic data elements, including Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and Nutritional Risk.

Specific demographic data elements shall include:

- Rural / Urban
- Gender
- Race
  - White
  - American Indian or Alaskan Native
  - Chinese
  - Japanese
  - Filipino
  - Korean
  - Vietnamese
  - Asian Indian
  - Laotian
  - Cambodian
  - Other Asian
  - Black or African American
  - Guamanian

REGISTERED SERVICES (cont.)

- Race (cont.)
  - Hawaiian
  - Samoan
  - Other Pacific Islander
  - Other Race
  - Multiple Race
- Ethnicity
  - Not Hispanic
  - Hispanic / Latino
- Poverty Status
- Living Arrangements
- Employment Status
- Relationship Status

Activities of Daily Living:

- Eating
- Bathing
- Toileting
- Transferring In and Out of Bed/Chair
- Walking
- Dressing

Instrumental Activities of Daily Living:

- Meal Preparation
- Shopping
- Medication Management
- Money Management
- Using Telephone
- Heavy Housework
- Light Housework
- Transportation

Nutritional Risk:

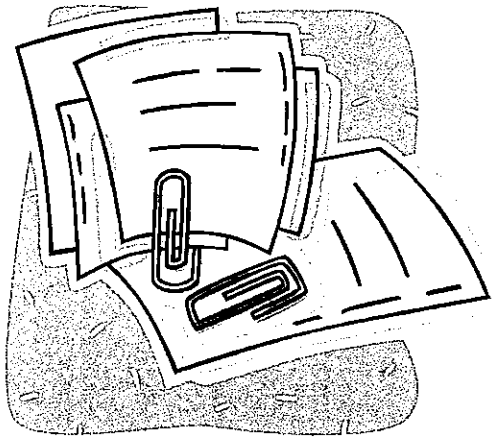
- Has an illness or condition that has changed the kind and/or amount of food eaten;
- Eats fewer than 2 meals per day;
- Eats few fruits and vegetables;
- Eats or drinks very few milk products;

REGISTERED SERVICES (cont.)

Nutritional Risk (cont.):

- Drinks less than 5 cups (8 oz.) of fluids a day;
- Has 3 or more alcoholic beverages every day;
- Has tooth or mouth problems that make it hard to eat;
- Doesn't always have enough money to buy needed food;
- Eats alone most of the time;
- Takes 3 or more prescribed or over-the-counter medications a day;
- Has involuntarily lost or gained 10 pounds in the last 6 months;
- Is not always physically able to shop, cook and/or eat.

NON-REGISTERED SERVICES



Supportive Services Program (SSP)

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NON-REGISTERED SERVICES

Non-Registered Services for SSP include:

- Alzheimer's Day Care Respite
- Respite Care
- Outreach
- Registry

Non-registered services **DO NOT** require "Detailed Client Profile" Information. Only units of service and number of clients served are required. For auditing purposes, Contractor shall keep, at a minimum, the following information:

- Client's Name
- Client's Phone number
- Client's Age
- Client's Zip code
- Services Requested

CASE/CARE MANAGEMENT

Supportive Services Program (SSP)

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CASE/CARE MANAGEMENT / BEST CASE PRACTICE

(Registered Service)

TASKS & PROCEDURES

The most important task of any program designed to prevent premature or inappropriate institutionalization of at risk elderly adults is the Case/Care Management process. The relationship that is established between the Case/Care Manager and the Client, as well as the quality of information that is gathered, is significant to a successful outcome. The relationship between the Case/Care Manager and the Client begins with the first contact. It is hoped that the information that is provided within this segment will be helpful in establishing a professional relationship with the client, as well as a successful outcome.

INQUIRY/ENROLLMENT PROCESS

Initial Contact

The case/care management process begins with the initial contact. The contact may be from a potential client or their representative. This inquiry may be:

- a phone call;
- the result of an outreach activity;
- a letter of inquiry.

CASE/CARE MANAGEMENT

TASKS & PROCEDURES (cont.)

Screening/Intake

The Screening/Intake process helps to determine the eligibility of the potential client and is also used to collect client demographics to determine if the client falls within the catchment area of the Contractor. During the Screening/Intake, the Agency will be able to determine the appropriateness of the potential client for enrollment in Case/Care Management.

Screening/Intake is generally conducted via a telephone interview with the potential client or client representative; however, a face-to-face interview may be necessary due to mobility issues of the potential client. If a potential client is deemed ineligible, that person must be referred to other appropriate resources available in the community. The reasons for ineligibility and referral resources shall be documented and filed.

Enrollment

Before the formal assessment begins, the Case/Care Manager should clearly explain the services available under Case/Care Management. It should also be made clear to the potential client that, in order to participate in the Program, he/she or a responsible other must provide informed consent to the arranged services.

The potential client shall also be informed that by signing a "consent to services form," the personal information relevant to the services provided may be shared among staff or other providers of services. A refusal on the part of the potential client will serve as a refusal to Case/Care Management services. A copy of the signed consent form must be given to the client.

Note: All pertinent data shall be entered on the form prior to asking the client to sign. Staff shall not ask the client to sign a blank form.

Client shall also be informed that clients able to pay for services may be asked to make a contribution towards the cost of services. The collection of client contributions is not mandatory, but based on voluntary participation. Under no circumstances shall a person be denied Program participation due to refusal to participate in the voluntary client contribution process.

CASE/CARE MANAGEMENT

TASKS & PROCEDURES (cont.)

Assessment

The assessment is an integral component of enrollment into the Program; and if at all possible, be conducted during a home visit. When appropriate, a "responsible other" and/or informal support may be in attendance. If the potential client is in a licensed care facility, a preliminary assessment may be conducted prior to the client's discharge; however, this shall be followed up by another assessment in the home.

The assessment reflects the client's level of functioning, which determines the development and direction of Care Planning. Should the assessment not be completed at the time of enrollment, the assessment shall be completed within two weeks of the initial contact date. The assessment shall include the Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and a Nutritional Risk Assessment.

A cognitive assessment may be indicated if the Case/Care Manager directly observes the client showing signs of memory loss, or receives information from the client's support system, i.e. family members, caregiver, neighbors, physician, etc. The client has a right to refuse service(s). However, when a client refuses service(s), the Agency must have a procedure in place to ensure that the risks associated with the refusal of service(s) are addressed to the best extent possible.

Care Planning

Care planning is the process of developing a service delivery approach to address the identified needs of the client. It is an agreement between the client and the Care/Case Manager to meet the identified client needs, the outcomes to be achieved, and the services to be provided in support of the established goal(s). It organizes the delivery system and helps ensure the service(s) being delivered is appropriate to the needs.

The Care Plan must be completed no later than two weeks from the date of the assessment. The Care Plan must include:

- problem areas which illustrate the need for care management;
- appropriate interventions/services to be arranged; and
- desired outcomes (goals).

The Care Plan must be developed and approved/signed by the client or "responsible other" and a copy of the Care Plan must be given to the client or "responsible other." Whenever a Care Plan is modified due to a reassessment or a client's changing needs, a copy of the modified plan must be given to the client or "responsible other."

CASE/CARE MANAGEMENT

TASKS & PROCEDURES (cont.)

Monitoring/Follow-Up

There must be, at a minimum, a monthly contact with the client. The contact may be by telephone when a face-to-face contact is not required. The purpose of contact is to:

1. Monitor and assess the efficacy or the services arranged; and
2. To assess the need for additional services/referrals or the elimination of services due to the goal(s) being met.

Progress Notes

Progress notes are the ongoing chronology of the client's record. They should address the provision of services planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress Notes shall include the following:

Each contact must be recorded in the client's Progress Notes. The progress notes should include:

1. Date/Time;
2. A summary of the conversation;
   a. Current client status
   b. Requests for additional and or elimination of services
3. Any agreed upon changes in services;
4. Commitments to client;
5. Follow-up Timeframes;
6. The type and frequency of staff contact with the client and/or "responsible other," and whether the contact was a home visit, telephone call, semi-annual home visit, reassessment, etc.
7. A record of all events which affect the client, i.e., hospitalization, collateral contacts with other agencies and/or service providers;
8. Evaluation comments on services delivered; and
9. An evaluation of the relationship between the identified needs and the services delivered.

CASE/CARE MANAGEMENT

TASKS & PROCEDURES (cont.)

Re-enrollment

A client may be re-enrolled in the Program if changes in the client's circumstances indicate a re-enrollment is warranted. The same eligibility requirements must be met. The same procedures must be met to re-enroll a client into the program. Such as:

- Face-to-face assessment
- Care Planning
- Monitoring/Follow-up
- Progress Notes
- Client De-activation / Termination

Client Deactivation/Termination

A client may be terminated either voluntary or involuntary. A client has the right to voluntarily terminate services at any time. If a client is involuntarily terminated, the Agency must provide a written notification to the client that must include:

- The basis for termination;
- Information on other agencies that could provide alternate services;
- The process for re-enrollment into the Program; and
- Procedures for filing a formal grievance.

If a client's condition has stabilized enough to function without care/case management, then every effort should be made to terminate services.

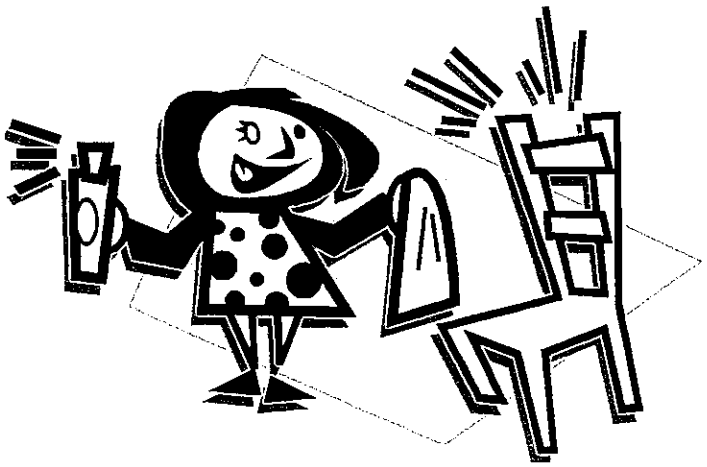
A client is subject to deactivation/termination under the following circumstances:

1. Deceased;
2. Moved out of Service Area;
3. No Longer Desires Services;
4. No Longer SNF Certifiable;
5. No Longer Medi-Cal Eligible;
6. Institutionalization;

Client Deactivation/Termination (cont.)

7. High Cost of Services;
8. Won't Follow Care Plan;
9. On Hold;
10. Service No Longer Needed;
11. Past Active;
12. On Waiting List;
13. Other Reason.

SERVICES



Supportive Services Program (SSP)

Title IIIB

Registered Services

HOMEMAKER

Homemaker is an in-home assistance service for a SSP client that provides household support and applies to the performance of household task rather than personal care for the client. This service is provided at the request of the client who needs outside help to maintain independent living. These services may include:

- Meal preparation;
- Basic household tasks; and
  - Laundry;
  - Dishwashing, etc.
- Light cleaning.

PERSONAL CARE

Personal Care is an in-home assistance service for a frail SSP client that provides personal support and applies to the performance of personal tasks rather than household tasks for the client. This service is provided at the request of the client who needs outside help to maintain independent living. These services may include:

- Activities of Daily Living;
  - Bathing
  - Toileting, etc.
- Bodily Hygiene; and
- Personal Safety.
  - Supervision of a frail or endangered elder who may suffer a medical emergency

Supportive Services Program (SSP)

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Non-Registered Services

IN-HOME RESPITE

In-Home respite provides for a temporary caregiver to provide temporary assistance to the Client in the absence of the regular caregiver. This service is provided at the request of the Client when the regular caregiver is seeking rest from the duties of caring for the Client.

> **Note:** A caregiver is defined as an individual who is providing regular care to the client, whether that care is compensated or uncompensated.

ALZHEIMER'S DAY CARE

Alzheimer's Day Care is provided to Clients who have been diagnosed with Alzheimer's disease and/or other related disorders with a neurological and organic brain dysfunction. Contractor must ensure that the services provided meet the special needs of, and address the behavioral problems of the Client. These services include:

- A written care plan;
- Dementia appropriate planned activities related to social, cognitive, and physical functioning;
- Observation of the Client for daily signs of illness, changes in behavior, or other conditions;
- Personal assistance and care for the Client in grooming, food spills on clothing, disarray of clothing, minor injuries, nail care, or their personal maintenance, when appropriate;
- Toileting assistance;

ALZHEIMER'S DAY CARE (cont.)

- Arrangement for a nutritious meal;
- Transportation by a family member or a transportation agency;
- Medication management;
    - This is to be provided only by a nurse or a comparable health professional that is licensed by the state of California.
- Infection and transmission control of transmittable diseases.

OUTREACH

Outreach is designed to identify potential Clients and encourage their use of the services available in the Supportive Services Program (SSP). The primary form of outreach shall be on a one-to-one basis, except when a specially targeted group presentation is deemed appropriate for a SSP outreach. Outreach is to provide information to the potential client on the services and benefits of the Program.

REGISTRY

Registry is a compilation and maintenance of a list of SSP providers offering Services that complement the care needed by the Client. It is the responsibility of the Contractor to recruit, screen, and connect providers with clients and clients with providers. Follow-up activities should be provided as necessary, to verify that the services met the needs of the Client.

Service Category	Unit Measure	Definitions	NAPIS Reference	Definition Reference	Primary Funding Source	Priority Service	Registered or Non-Registered
AAA Activities and CARS Reporting							
Personal Care	1 Hour	Personal assistance, stand-by assistance, supervision or cues. (such as with eating, bathing, toileting, transferring in/out of bed/chair, walking, dressing, grooming).	NAPIS 1	NAPIS Div 4000 Unit 20	Title III B	Yes	Registered
Homemaker	1 Hour	Assistance such as preparing meals, shopping for personal and household items, managing money, using the telephone or doing light housework.	NAPIS 2	NAPIS Div 4000 Unit 50, Unit 27	Title III B	Yes	Registered
Case Management	1 Hour	Assistance either in the form of access coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.	NAPIS 6	NAPIS Div 4000 Pr 3	Title III B	Yes	Registered
Outreach	1 Contact	Interventions (one-on-one contacts with individuals) with individuals initiated by an agency or provider for the purpose of identifying potential clients (or their age 60+ caregivers) and encouraging their use of existing services and benefits.	NAPIS 14	NAPIS Div 4000 Unit 19	Title III B	Yes	Non-Registered
Alzheimer's Day Care Services	1 Day of Attendance	Day of attendance (four hours minimum) at a licensed Adult Day Care or Adult Day Health Care Center that provides Alzheimer's or dementia services.	NAPIS 15 - Other	Div 4000 Pr 6	Title III B	Yes	Non-Registered
Registry	1 Hour	Recruit workers, maintain a current list of qualified workers, refer workers to clients or clients to workers, and follow-up to assure that service was received.	NAPIS 15 - Other	Div 4000 Unit 41	Title III B	No	Non-Registered
Respite Care	1 Hour	Arrange for relief of the relatives or other caregivers of the frail elderly living at home by the coordination or direct provision of supportive services to the older person(s) while the primary caregiver is temporarily absent (includes Adult Day Care as a respite service for families).	NAPIS 15 - Other	Div 4000 Pr 18, Unit 45	Title III B	Yes	Non-Registered

PERFORMANCE REQUIREMENTS SUMMARY (PRS) CHART
SUPPORTIVE SERVICES PROGRAM - TITLE III B
2010-2014

The Performance Requirements Summary (PRS) Chart is a listing of some of the required services and performances that will be monitored during the Contract term. The PRS Chart also lists examples of the types of documents that will be used during monitoring (e.g., SAMS Reports are reports produced from CSS' current IT System as stated in the SOW, Section 13.0), as well as the standards of performance, and the acceptable quality level of performance.

All listings of required services or standards used in this PRS Chart are intended to be completely consistent with the terms and conditions of the Contract and the Statement of Work (Exhibit A to the Contract) and are not meant in any case to create, extend, revise, or expand any obligation of the CONTRACTOR beyond that defined in the terms and conditions of this Contract and Statement of Work. In any case of apparent inconsistency between required services or standards as stated in the terms and conditions of the Contract, the Statement of Work, and this PRS Chart, the terms and conditions of the Contract and the Statement of Work (SOW) will prevail.

Performance Outcomes	Standards	Acceptable Quality Level	Data Source	Remedies for Non-Compliance
Enable seniors to live independently in their homes, as long as possible.	Of those clients terminated from the program, decrease the exits due to institutionalization by 10 percent.	95%	SAMS Reports	If CONTRACTOR performance does not meet the Acceptable Quality Level, the COUNTY will have the option to apply the following remedies: 1) Corrective Action Plan, 2) Suspension of Payment; 3) Suspension of Contract; and, 4) Termination of Contract.
Key Measures	**Standards**		**Data Source**	
Client Intake	Complete a client intake within 14 days of initial client contact.		SAMS Reports	
Service Provision	Ensure that all clients begin receiving services within 14 days of completing the client intake process.		SAMS Reports	
Client Follow-Up	Maintain monthly telephone contact with 100% of clients to ensure the effectiveness of arranged services and to modify those services as needed.		SAMS Reports	
Client Reassessment	Conduct a face-to-face reassessment with 100% of ongoing clients on a semi-annual basis.		SAMS Reports	